State of California—Health and Human Services Agency

Department of Health Services
WIC Supplemental Nutrition Branch

WIC REFERRAL FOR PREGNANT WOMAN

Health Care Provider:
Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

Patient's name (last, first)	Address (street, city, ZIP)	Telephone number	Birthdate

WOMAN'S CURRENT (PRENATAL)

Height _____ ins. _____/_____/_____ (Measurement date)
Weight _____ lbs.
Hemoglobin _____ gm/dl. _____/_____/_____ (Blood test date)
and/or
Hematocrit _____ %

Est. date confinement _____/_____/_____
Date last preg. ended _____/_____/_____
Gravida _____ Para _____
Pregravid weight _____ lbs.

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN:

- ❒ Diabetes
- ❒ Multiple Pregnancy
- ❒ Hypertension
- ❒ Tuberculosis ____+PPD ____ INH
- ❒ Previous poor pregnancy outcome/history (specify):

_____

_____

- ❒ Other current or historical conditions (specify):

_____

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

_____

_____

_____

IMPRESSIONS/COMMENTS:

_____

_____

_____

LOCAL WIC AGENCY

Name of physician/health care provider/group/clinic

Telephone Number:

IMPORTANT: Must be signed by health care provider Date

The United States Department of Agriculture (USDA) prohibits discrimination in its programs on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, or marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington, DC, 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

PM 247 (4/99)

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WIC REFERRAL FOR POSTPARTUM/BREASTFEEDING WOMAN

Health Care Provider:
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Patient's name (last, first)	Address (street, city, ZIP code)	Telephone number	Birthdate

WOMAN'S CURRENT (After Delivery)

Height _____ ins.
Weight _____ lbs. _____/_____/_____ Measurement date
Hemoglobin _____ gm/dl.
and/or
Hematocrit _____ % _____/_____/_____ Blood test date

PREGNANCY OUTCOME

_____/____/_____ Delivery date

	Full-Term	Preterm (37 wks.)	Sm. Gest. Age	Fetal Loss	Stillbirth	Sex	Birth weight	Birth length
1.	❒	❒	❒	❒	❒			
2.	❒	❒	❒	❒	❒			

Please describe any medical conditions affecting the infant(s):

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.

❒ C-Section
❒ Diabetes
❒ Hypertension
❒ Tuberculosis
____+PPD ____INH
❒ Other conditions occurring during this pregnancy or delivery (specify):_____
❒ Other current or historical medical conditions (specify):

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

IMPRESSIONS/COMMENTS:

LOCAL WIC AGENCY

Name of physician/health care provider/group/clinic

Telephone number:

IMPORTANT: Must be signed by health care provider Date

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Patient's name (last, first) | Address (street, city, ZIP code) | Telephone number | Birthdate

WOMAN'S CURRENT (After Delivery)

Height _____ ins.
Weight _____ lbs. _____/_____/_____ Measurement date
Hemoglobin _____ gm/dl.
and/or
Hematocrit _____ % _____/_____/_____ Blood test date

PREGNANCY OUTCOME

_____/____/_____ Delivery date

Full-Term | Preterm (37 wks.) | Sm. Gest. Age | Fetal Loss | Stillbirth | Sex | Birth weight | Birth length

1. ❒ ❒ ❒ ❒ ❒
2. ❒ ❒ ❒ ❒ ❒

Please describe any medical conditions affecting the infant(s):

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.

❒ C-Section
❒ Diabetes
❒ Hypertension
❒ Tuberculosis
____+PPD ____INH
❒ Other conditions occurring during this pregnancy or delivery (specify):_____
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